Nevada State Board of Medical Examiners

Renewal Responses Report

Thursday, September 18, 2014

License Number	Licensee	License Type
14659	DeShawn LaKisha TAYLOR	Medical Doctor

Question	Answer	Date
Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? **If you do not have a medical condition, select No.**	N	06/26/2013
If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? **If you do not have a medical condition, select No.**	N	06/26/2013
If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? **If you do not use chemical substances, select No.**	N	06/26/2013

Have you been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, malpractice, including any military tort claims if applicable? Please include: who, what, where (provide state), and when in the textbox directly below this question.	N	06/26/2013
Have you had a professional liability, malpractice, claim paid on your behalf or paid such a claim yourself including any military tort claims if applicable? If "Yes" during the time period July 1, 2011 - June 30, 2013 type an explanation in the textbox directly below this question.	N	06/26/2013
Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any offense or violation of any federal (including the Uniform Code of Military Justice), state or local law, or the laws of any foreign country, which is a misdemeanor, gross misdemeanor, felony, violation of the Uniform Code of Military Justice, or synonymous thereto in a foreign jurisdiction, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of a chemical substance, including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? **Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, or expungement.**	N	06/26/2013
Have you been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory?	N	06/26/2013

Have you had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory?	N	06/26/2013
Have you voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory in lieu of any disciplinary action?	N	06/26/2013
Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education?	N	06/26/2013
Have you been: a) asked to respond to an investigation; b) notified that you were under investigation for; c) investigated for; d) charged with; or e) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or agency other than the Nevada State Board of Medical Examiners?	N	06/26/2013

Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?	N	06/26/2013
Have you had hospital staff privileges denied, suspended, limited, revoked or not renewed by the hospital, including any and all resignations from any medical staff in lieu of disciplinary or administrative action? If the answer is " Yes," type the name of the hospital, the hospital`s mailing address, the type of action taken, and the date or dates of the actions taken in the textbox directly below this question. **(Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.)**	N	06/26/2013
Have you actively practiced medicine in Nevada within the past 12 months?	Y	06/26/2013
I hereby request my license to be placed on Inactive status, which means I will not physically practice in the state of Nevada. If you choose to place your license on Inactive status, make certain to select "Yes" to this question **AND** choose the Inactive status in the dropdown box located at the end of the questions.	N	06/26/2013

The submission of the in-office surgery/procedure forms is required for all medical doctors, whether in state, out of state, active or inactive status! THIS IS NOT OPTIONAL. DO NOT answer this attestation until you have completed the requisite form. Once you have completed this action, you may proceed in answering the renewal attestations and questions. The online renewal site will retain your previous responses. Please go to the website, click on the following link for instructions and complete the required form.Click on the following link for the instructions and forms: http://medboard.nv.gov/New_In_Office_Surgery_Forms.htm **If you have submitted your In-Office Surgery/Procedure Reporting Forms (A/B forms) to the Board and are in compliance with NRS 630.30665, your answer should be**	Y	06/26/2013
Are you out of compliance with court ordered child support? **If this does not apply to you, please answer "no".** If "Yes" during the time period July 1, 2011 - June 30, 2013 type an explanation in the textbox directly below this question.	N	06/26/2013
I have completed the required amount of AMA Category 1 CME within the current biennial. I understand that I may be included in a random audit. I agree to retain CME's taken between July 1, 2011 and June 30, 2013. (Review CME information online at www.medboard.nv.gov) If renewing to an Inactive status, CME is not required and "No" can be selected.	Y	06/26/2013
I SWEAR OR AFFIRM UNDER THE PENALTY OF PERJURY THAT I PERSONALLY ANSWERED ALL OF THE QUESTIONS IN THIS APPLICATION AND THAT THE ANSWERS I HAVE PROVIDED ARE TRUE AND CORRECT.	Y	06/26/2013

Uniform Application for Physician Licensure

UA Username deshawntmd **Date Submitted** 12/10/2012
FCVS Status Applicant has an FCVS Packet

1. Name: Indicate your full legal name. If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

1. Full Name (use no initials)

Last Name Taylor
First Name DeShawn
Middle Name LaKisha
Suffix
Maiden Name
M.D. [X] **D.O.** [ ]

All other names used

First	Middle	Last	Suffix
DeShawn	LaKisha	Taylor-Harris	
De Shawn		Harris	
DeShawn		Taylor	

2. Address/Phone: Please complete all sections and indicate which address you wish to be used for public access and which is to be used for mailings from the medical board. Each state's law determines whether each address or phone number is a public record in the state in which you are applying. You may wish to contact the licensing authority for that state for further information. Many boards publish the "Public Access" address on their website, therefore you should consider what your preferred address is for these purposes.

2. Address/Phone

Business
[X] **Public Access**
[ ] **Mailing**

Street 1331 N. 7th. Street
Suite 225
City Phoenix **State/Province** AZ **Zip Code** 85006
Country USA
Telephone 602-553-0440
Fax 602-462-5588
Email frontdesk@fpa.com
Alternate Phone

Home
[ ] **Public Access**
[X] **Mailing**

Street
City **State/Province** **Zip Code**
Country USA
Telephone
Fax
Email
Alternate Phone

3. Identification: If you are not using FCVS, you must submit either a notarized copy of your birth certificate or a notarized copy of your current, valid passport.

3. Identification

/1975		California	USA
Date of Birth (mm/dd/yyyy)	Birth City	Birth State/Province	Birth Country

F (Gender) ____ (Social Security Number) ____ (NPI) Are you a U.S. Citizen? [X] Yes [ ] No

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. Section 666 and applicable state law). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with state laws governing physician discipline or as otherwise required by state or federal law.

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. For more information on the NPI, please go to http://www.cms.hhs.gov/NationalProvidentStand/.

4. Medical School: List all medical schools you have attended, even those from which you did not graduate, in chronological order. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Medical Education Verification" form and send it to all medical schools you have attended. You must include a copy of your diploma to which the medical school must attach their seal prior to forwarding it to this Board. Additionally, the medical school must provide this Board with an official copy of your transcripts. The medical school must forward all documentation directly to this Board.

4. Medical School

1 **School Name** University of California Los Angeles, David Geffen School of Med
Address 10833 Le Conte Avenue

City Los Angeles
State/Province CA
ZIP Code 90095
Country USA
Attendance Dates **From (mm/yyyy)** 08/1997 **To (mm/yyyy)** 06/2001
Graduation Date 6/1/2001
Degree MD

5. Fifth Pathway: If you attended a Fifth Pathway program and are not using FCVS, you must complete the attached "Fifth Pathway Verification" form and send it to your medical school and to the institution where you completed your rotations. You must include a copy of your diploma. The medical school and institution must forward all documentation directly to this Board.

5. Fifth Pathway (if applicable)

Medical School Name			
Address			
City			
State/Province			
ZIP Code			
Country			
Attendance Dates	**From (mm/yyyy)**	**To (mm/yyyy)**	**In Progress**
Graduation Date			
Degree			
Institution name where rotations performed			
Address			
City			
State/Province			
ZIP Code			
Country			
Rotation Dates	**From (mm/yyyy)**	**To (mm/yyyy)**	**In Progress**
Certification Date			

6. Postgraduate Training: List **all** postgraduate programs you have attended, even those you did not complete. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Postgraduate Training Verification" form and send it to **all** postgraduate training programs you have attended. You must submit a copy of your certificate of program completion to this Board. The postgraduate program must forward all documentation directly to this Board.

6. Postgraduate Training

1 **Hospital Name** LAC/USC Medical Center
Hospital Address 1200 N. State St

City Los Angeles
State/Province California
ZIP Code 90033
Country USA

PGY: (e.g., 1, 2, 3, etc.) ☐ **Internship** ☐ **Residency** ☒ **Fellowship** ☐ **Research** ☐ **Other**

Department/Specialty Family Planning

From: 07 /2005 **To:** 06 /2007 **Successfully Completed?** ☒ **Yes** ☐ **No** **In Progress** ☐
Month Year Month Year

2 **Hospital Name** Martin Luther King Jr Drew Medical Center
Hospital Address 12021 South Wilmington Avenue

City Los Angeles
State/Province California
ZIP Code 90059
Country USA

PGY: (e.g., 1, 2, 3, etc.) ☒ **Internship** ☒ **Residency** ☐ **Fellowship** ☐ **Research** ☐ **Other**

Department/Specialty Obstetrics and Gynecology

From: 07 /2001 **To:** 06 /2005 **Successfully Completed?** ☒ **Yes** ☐ **No** **In Progress** ☐
Month Year Month Year

7. Examination History: If you are not using FCVS, you are responsible for contacting the appropriate examination entity and having a certified transcript of your scores sent directly to this Board.

7. Examination History

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, Etc.).If additional space is necessary, please enclose a separate sheet with your application and include all the information below

Examination	State	Most Recent Date taken(Month/Year)	Passed (P) or Failed (F)		Number of attempts
USMLE Step 1			[X] P	[ ] F	1
USMLE Step 2			[X] P	[ ] F	1
USMLE Step 3			[X] P	[ ] F	2

8. ECFMG: If ECFMG is applicable and you are not using FCVS, you are responsible for contacting ECFMG and having a certified "Status Report" forwarded directly to this Board. There is a separate fee for this report. Reports can be obtained through the ECFMG web site at www.ecfmg.org.

8. ECFMG (if applicable)

Certificate Number	Issue Date	Valid Through Date

9. State or Professional Licensure: List all state and Canadian provinces where you currently hold or have ever held any type of medical/osteopathic license. You must also complete the attached "Licensure Verification" form (Form #1) and forward it to all states in which you have held any health care license or certification. The verifying entity must forward all documentation directly to this Board. Some state boards charge a fee for this information. Contact the state board where you hold or held a license to determine their requirements.

9. State Licensure

1	**State/Province**	AZ	**Practitioner Type (MD, DO, etc.)**	MD	**Type of License (Full, Temporary, etc.)**		
	License Number	41803	**Status**	Active	**Issue Date**	4/1/2009	
2	**State/Province**	CA	**Practitioner Type (MD, DO, etc.)**	MD	**Type of License (Full, Temporary, etc.)**		
	License Number	A83243	**Status**	Active	**Issue Date**	5/1/2003	

10. Chronology of Activities: List ALL activities (medical, non-medical, and postgraduate training) in chronological order beginning with medical school graduation to the PRESENT date, using **MONTH** and **YEAR**. *For any non-working time, you MUST state on the form exactly what your activities were, such as "vacation" or "seeking employment," as well as your permanent address.* If you worked for a physician-staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses. **DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM**. Be sure to indicate the percentage of working time spent in clinical administrative duties.

10. Chronology of Activities

Dates: From/To	Practice/Employment
1 From: Month: 07 Year: 2001 To: Month: 06 Year: 2005 In Progress ☐	**Practice/Employment Name** MLK/Drew Medical Center (or list non-working time as indicated above) **Practice/Employment Address** 12021 S. Wilmington **City** Los Angeles **State/Province** California **ZIP Code** 90069 **Country** USA **Position and Department** Resident-Ob/Gyn **Percent Clinical:** 90% **Percent Administrative:** 10% **Employment** ☒ **Staff Privileges** ☐ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
2 From: Month: 07 Year: 2005 To: Month: 06 Year: 2007 In Progress ☐	**Practice/Employment Name** LAC/USC Medical Center (or list non-working time as indicated above) **Practice/Employment Address** 1200 N. State St **City** Los Angeles **State/Province** California **ZIP Code** 90033 **Country** USA **Position and Department** Family Planning Fellow / Clinical Instructor-Ob/Gyn **Percent Clinical:** 90% **Percent Administrative:** 10% **Employment** ☒ **Staff Privileges** ☒ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
3 From: Month: 09 Year: 2005 To: Month: 04 Year: 2006 In Progress ☐	**Practice/Employment Name** MLK/Drew Medical Center (or list non-working time as indicated above) **Practice/Employment Address** 12021 S. Wilmington **City** Los Angeles **State/Province** California **ZIP Code** 90069 **Country** USA **Position and Department** Clinic Physician-Ob/Gyn **Percent Clinical:** 100% **Percent Administrative:** 0% **Employment** ☐ **Staff Privileges** ☒ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
4 From: Month: 07 Year: 2007 To: Month: 03 Year: 2010 In Progress ☐	**Practice/Employment Name** Keck School of Medicine, University of Southern California (or list non-working time as indicated above) **Practice/Employment Address** LAC/USC Medical Center 1200 N. State Street **City** Los Angeles **State/Province** California **ZIP Code** 90033 **Country** USA **Position and Department** Assistant Professor of Clinical Obstetrics and Gynecology-Ob/Gyn **Percent Clinical:** 40% **Percent Administrative:** 60% **Employment** ☒ **Staff Privileges** ☒ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
5 From: Month: 07 Year: 2009 To: Month: 10 Year: 2012 In Progress ☐	**Practice/Employment Name** Planned Parenthood Arizona, Inc (or list non-working time as indicated above) **Practice/Employment Address** 5651 N. 7th Street **City** Phoenix **State/Province** Arizona **ZIP Code** 85014 **Country** USA **Position and Department** Vice President of Medical Affairs / Medical Director-Medical Affairs **Percent Clinical:** 40% **Percent Administrative:** 60% **Employment** ☒ **Staff Privileges** ☐ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
6 From: Month: 11 Year: 2012 To: Month: Year: In Progress ☒	**Practice/Employment Name** Family Planning Associates Medical Group (or list non-working time as indicated above) **Practice/Employment Address** 1331 N. 7th Street Suite 225 **City** Phoenix **State/Province** Arizona **ZIP Code** 85006 **Country** USA **Position and Department** Independent Contractor-Ob/Gyn **Percent Clinical:** 100% **Percent Administrative:** 0% **Employment** ☒ **Staff Privileges** ☐ **Affiliation** ☐ **Other**

11. Malpractice: List of all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization. If you do not have any such claims or suits, this section will be blank. Please have your information available before reviewing this section and contact the state board or FCVS to make changes.

11. Malpractice Liability Claims Information

Name of patient involved:

In which state did the action take place? **Case number (if applicable)**

Which court?
(If private compromise or settled before initiation of civil action, state here)

Current status of claim:

☐ Open (pending) ☐ Closed (settled or judgment) ☐ Dismissed (no money paid out) ☐ Other

Amount of judgement or settlement $ **Amount paid on your behalf $**

Month and year of event precipitating claim:

Month and year of lawsuit:

Insurance carrier at time:

What is/or was your status? ☐ **Primary defendant** ☐ **Co-defendant** ☐ **Other**

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

Uniform Application Supplemental Page

USMLE Examination history

Step 1	6/1999	84
Step 2 CK	9/2000	84
Step 3	6/2002	74
Step 3	11/2002	80

State licenses

Arizona license was issued 4/30/2009
California license was issued 5/21/2003

American Board of Medical Specialties

ABOG initial certification granted November 2009
ABOG Maintenance of Certification granted December 2010

DeShawn Taylor, MD 01-17-2013

7/1/2011 - 6/30/2013 PHYSICIAN
APPLICATION FOR LICENSURE
NEVADA STATE BOARD OF
MEDICAL EXAMINERS
Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559

Date Received by Board: RECEIVED DEC 17 2012 NEVADA STATE BOARD OF MEDICAL EXAMINERS

License No: _____

File No: _____

(For Board Use)

ADDENDUM 2

INITIAL APPLICATION INFORMATION

1. Present Legal Name TAYLOR (Last) DE SHAUN (First) LA KISHA (Middle) _____ (Maiden)

2. Contact Information: Telephone Number (602) 553-0440 (Office) ( ) _____ (Home)

Fax Number (602) 462-5588 Cellular Number (Optional) ( ) _____

Email address____

3. Please indicate the COUNTY in which your home address and practice address are located.

County of Home Address: MARICOPA

County of Practice Address: MARICOPA

4. Date of Birth _____ _____ 1975
(Month / Day / Year)

5. Social Security Number_____

6. Citizenship: Alien Registration # N/A Employment Authorization # _____ Applying for Visa_____

Submit a certified birth certificate or original Certificate of Naturalization or current U.S. passport or copy of the front and back of your alien registration card, Employment Authorization or Visa. Please note: Copy of document authorizing a name change (marriage license, divorce decree, etc) must be included.

7. Physical Identification:

Color of Eyes __ Color of Hair _ Height _ _____ Weight _____

8. State your scope of practice/specialty(ies): OB/GYN

9. List any and all certifications and re-certifications by a board or sub-board recognized by the **AMERICAN BOARD OF MEDICAL SPECIALTIES**.

Specialty Board	Certification #	Dates of Certification/Recertification (Mo/Yr)
ABOG	9011579	1/2011

10. If you hold "lifetime or historical" ABMS Board certification, please provide a notarized statement agreeing to maintain Board certification for the duration of your licensure in the state of Nevada.

Print Name: Last TAYLOR **First** DE SHAUN **Middle** LA KISHA

11. List below the requested information for all hospitals or surgery centers in which you **ARE, OR HAVE EVER BEEN** a staff member at any level during the last ten years. If none, please indicate. Do not list internship, residency or fellowship affiliation.

Hospital	Complete Mailing Address	Dates of Appointment From (Mo./Yr.)	To (Mo./Yr.)
BANNER GOOD SAMARITAN MED CTR	1111 E MCDOWELL RD PHOENIX, AZ 85006	3/2010	PRESENT
LAC+USC MEDICAL CENTER	1200 N. STATE ST. LOS ANGELES CA, 90033	7/2005	3/2011
MLK/DREW MEDICAL CENTER	12021 S. WILMINGTON AVE LOS ANGELES, CA 90059	9/2005	4/2006

(All information must begin on this form, if more space is needed, please attach a separate sheet.)

Print Name: Last TAYLOR **First** DESHAWN **Middle** LA KISHA

ADDENDUM 3

FOR ALL "YES" RESPONSES TO THE FOLLOWING QUESTIONS, YOU MUST SUBMIT YOUR WRITTEN EXPLANATION(S) ON A SEPARATE SHEET.

For the purposes of the following questions, these phrases or words have these meanings:

Ability to practice medicine is to be construed to include all of the following:

- The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and
- The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
- The physical capability to perform medical tasks such as physician examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

Medical condition includes physiological, mental or psychological condition or disorder.

Chemical substances is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescribers direction.

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1. Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? ____Yes __X__No

2. If you currently have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? ____Yes ____No __X__N/A

3. If you currently use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? ____Yes ____No __X__N/A

4. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? ____Yes __X__No

5a. Have you EVER been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, or malpractice, including any military tort claims if applicable? (IF ANSWER IS "YES", YOU MUST COMPLETE ADDENDUMS 4 AND 5.) ____Yes __X__No

5b. Have you EVER had a professional liability, malpractice, claim paid on your behalf, or paid such a claim yourself including any military tort claims if applicable? ____Yes __X__No

6. Have you EVER been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any offense or violation of any federal (including the Uniform Code of Military Justice), state or local law, or the laws of any foreign country, which is a misdemeanor, gross misdemeanor, felony, violation of the Uniform Code of Military Justice, or synonymous thereto in a foreign jurisdiction, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of a chemical substance, including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? *Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissed, or expungement. (If "Yes," attach explanation on separate sheet.) ____Yes __X__No

7. Have you previously applied for medical licensure in Nevada (including a residency program)? ____Yes __X__No

8. Have you EVER been the subject of an investigation (including matters that resulted in no adverse action or outcome to you) have you resigned, been dismissed, or have any actions, form of remediation(s), restrictions, limitations, probations, terminations or any other disciplinary actions ever been imposed on you while participating in any type of training program? (If "Yes," attach explanation on separate sheet.) ____Yes __X__No

9. Have you EVER been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory? (If "Yes," attach explanation on separate sheet.) ____Yes __X__No

10. Have you EVER had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? (If "Yes," attach explanation on separate sheet.) ____Yes __X__No

11. Have you EVER voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory? (If "Yes," attach explanation on separate sheet.) ____Yes __X__No

12. Have you EVER been denied membership, asked to resign, or expelled from a medical society or other professional medical organization? (If "Yes," attach explanation on separate sheet.) ____Yes __X__No

13. Have you EVER been: a) asked to respond to an investigation; b) notified that you were under investigation for; c) investigated for; d) charged with; or e) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or agency other than the Nevada State Board of Medical Examiners? (If "Yes," attach explanation on separate sheet.) ____Yes __X__No

Print Name: Last TAYLOR **First** DE SHAWN **Middle** LA KISHA

14. Have you EVER surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? _____Yes X No
(If "Yes," attach explanation on separate sheet.)

15. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any (all) resignations from any medical staff in lieu of disciplinary or administrative action. (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance).

Hospital	Mailing Address	Type of Action	Dates of Action From (Mo./Yr.)	To (Mo./Yr.)
N/A				

RECEIVED
DEC 17 2012
NEVADA STATE BOARD OF MEDICAL EXAMINERS

(All information must begin on the application, if more space is needed, please attach separate sheet.)

CHILD SUPPORT STATEMENT

The law of the state of Nevada requires that all applicants for issuance of a license be required to provide the following information concerning the support of a child. You are advised that this questions is part of your application, your response is given under oath, and any response hereto which is false, fraudulent, misleading, inaccurate or incomplete, may result in your application being denied. You must mark one of the following responses, and failure to mark one of the responses may result in denial of your application.

Please place a check mark next to one of the following statements:

X (a) I am not subject to a court order for the support of a child;

_____ (b) I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; **OR**

_____ (c) I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

SAFE INJECTION PRACTICE ATTESTATION

ATTESTATION TO KNOWLEDGE OF AND COMPLIANCE WITH THE GUIDELINES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION FOR APPLICANT PHYSICIANS

I hereby attest to knowledge of and compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices. I also attest that any person who is currently, or will be under my control as their supervising physician in the future, and who is not licensed pursuant to chapter 630 of the Nevada Revised Statutes and whose duties involve injection practices, has knowledge of and is in compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices.

Applicant: _____ Date: 12/12/12

Print Name: Last TAYLOR **First** DeSHAWN **Middle** LA KISHA

I, DeSHAWN LAKISHA TAYLOR, M.D.
(print your full name)

being duly sworn, depose and say: That the answers to the foregoing questions and statements made in the above application as well as any and all further explanations contained on any separate attached pages are true and correct, that I am the person named in the credentials to be submitted, and that the same were procured in the regular course of instruction and examination without fraud or misrepresentation. I understand that if any of my responses on this application are false, fraudulent, misleading, inaccurate, or incomplete, my application for licensure will be denied.

I am responsible to keep the Board informed of any circumstance or event that would require a change to my initial responses provided to the Board in my application for licensure, and which occur prior to my being granted licensure to practice medicine in the State of Nevada.

Signature of applicant _____ Date 12/11/12

(NOTARY SEAL)

Notary Public State of Arizona
Maricopa County
Linda M Torres
My Commission Expires 03/28/2016

State of AZ County of MARICOPA
Subscribed and sworn to before me this 11th day of December, 2012.
Notary Public for the State of Arizona
My Commission Expires: 3/28/2016
Residing at: 1331 N. 7th St.
City State
Linda M. Torres
Signature of Notary

RECEIVED
DEC 17 2012
NEVADA STATE BOARD OF MEDICAL EXAMINERS

Print Name: Last TAYLOR **First** DeSHAWN **Middle** LAKISHA

denial, revocation, or other disciplinary

Applicant's Signature (must be signed in the presence of a notary)

TAYLOR

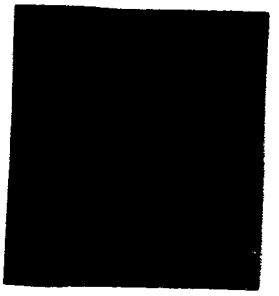
Applicant's Printed Last Name

DESHAWN L.

Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

12/11/12

Date of Signature



NOTARY

Dated 12-11-12 Signed Linda M. Torres

State of AZ County of Maricopa

SUBSCRIBED AND SWORN TO before me this 11th day of, December 20 12

My commission expires: _____ (NOTARY PUBLIC SIGNATURE & SEAL)

Notary Public State of Arizona
Maricopa County
Linda M Torres
My Commission Expires 03/28/2016

ADDENDUM 1

ATTENTION APPLICANT!

RESPONSIBILITY STATEMENT

Please sign and return this statement with your application for licensure to:
The Nevada State Board of Medical Examiners,
P.O. Box 7238, Reno, NV 89510
or
1105 Terminal Way, Ste 301, Reno, NV 89502

Because you are applying for the privilege of practicing medicine in Nevada, you should know that our state has some of the most stringent licensing requirements and comprehensive investigation programs in the United States.

Via FBI fingerprinting and other investigative modalities, our licensing specialists are likely to discover if data you have submitted on your application is erroneous or incomplete; therefore, you must answer all questions truthfully and completely. Specifically, this includes any sanctions or disciplinary actions you may have experienced during medical school or your postgraduate training, or any involvement you may have had with the legal system, either civil or criminal — criminal to include charges that may have ultimately been expunged, lessened, or dismissed, and no matter how long ago the event(s) occurred.

Explaining and documenting a problem to your licensing specialist will be much less painful than discussing your veracity before the entire Board of Medical Examiners due to inconsistencies between your application and incongruent input from outside sources.

ONLY YOU — NOT A LAWYER, DOCTOR, SPOUSE, OR CREDENTIALING COMPANY — ARE RESPONSIBLE FOR READING AND ANSWERING EVERY QUESTION ACCURATELY AND COMPLETELY.

If you have *any* questions about your application, ASK YOUR LICENSING SPECIALIST. Our licensing specialists are here to help you.

o o o o o

I have read this responsibility statement and understand that I alone am accountable for completing my application for medical licensure in Nevada.

Print your name DE SHAWN TAYLOR, MD.

Sign your name _____

Date 12/12/12

Note: It is your responsibility to keep the Board informed of any circumstance or event that would require a change to your initial responses provided to the Board in your application for licensure, and which occur prior to you being granted licensure to practice medicine in the State of Nevada.

Print Name: Last TAYLOR **First** DESHAWN **Middle** LA KISHA

ADDENDUM 9

PERMISSION TO SEEK CRIMINAL BACKGROUND INVESTIGATION REPORT AND TO OBTAIN AND USE A SET OF MY FINGERPRINTS IN THIS REGARD

I understand that all applicants applying for licensure with the Nevada State Board of Medical Examiners, pursuant to the Nevada Revised Statutes, Chapter 630, must submit a full set of his/her fingerprints, along with an authorization for the Nevada State Board of Medical Examiners to forward his/her fingerprints to the Department of Public Safety Records and Technology Division and to the Federal Bureau of Investigation for a state and federal criminal background investigation and report.

I herewith and hereby grant permission and fully authorize the Nevada State Board of Medical Examiners to submit a complete set of my fingerprints to the Department of Public Safety Records and Technology Division for submission to the Federal Bureau of Investigation for their reports.

I UNDERSTAND THAT THE COSTS OF FINGERPRINTING, THE BACKGROUND CHECK AND THE REPORT SHALL BE AT MY OWN EXPENSE.

Dated this 12 day of December, 2012

RECEIVED
DEC 17 2012
NEVADA STATE BOARD OF MEDICAL EXAMINERS

Signature of Applicant

DeShawn TAYLOR, M.D.
Print Name

By signing my signature on the line below, I do hereby understand that I must timely submit my fingerprints to the Nevada State Board of Medical Examiners in order for the Board to submit a complete set of my fingerprints to the Department of Public Safety Records and Technology Division for submission to the Federal Bureau of Investigation for their reports. Failure to do so could result in disciplinary action up to and including immediate summary suspension of my license. NRS 630.167.

Signature of Applicant

12/12/12
Date

Return this form to:

Nevada State Board of Medical Examiners
1105 Terminal Way, Ste. 301, Reno, NV 89502
or
P.O. Box 7238
Reno, NV 89510

Print Name: Last TAYLOR **First** DeSHAWN **Middle** LAKISHA

Nevada Department of Public Safety

CIVIL APPLICANT WAIVER

In consideration for processing my application I, the undersigned, whose name and signature voluntarily appears below; do hereby and irrevocably agree to the following:

1. I hereby authorize (enter name of submitting agency) Nevada Medical Board (NSBME), to submit a set of my fingerprints to the Nevada Department Public Safety, Records Bureau for the purpose of accessing and reviewing Nevada and National criminal history records that may pertain to me.
In giving this authorization, I expressly understand that the information may include information pertaining to notations of arrest, detainments, indictments, information or other charges for which the final court disposition is pending or is unknown to the above referenced agency. For records containing final court disposition information, I understand that the release may include information pertaining to dismissals, acquittals, convictions, sentences, correctional supervision information and information concerning the status of my parole or probation when applicable. Further, I understand that the information may include similar information obtained from other local, state and federal criminal justice agencies and may include information pertaining to convicted person data, outstanding arrest warrants, missing persons.

2. **In giving the above authorization, I understand that all information provided to the submitting agency may be reviewed by the submitting agency or any other employee within the submitting agency's organization deemed necessary to make an informed decision. This information is confidential, as relating to a third party beyond that of the submitting agency's company and/or its subsidiary company(s) and of criminal justice agencies in the performance of their official duties, and may not be further disseminated.** (Please initial) LDJ

3. I understand that I may review and challenge the accuracy of any and all criminal history records which are returned to the submitting agency, and that the proper forms and procedures will be furnished to me by the Nevada Department of Public Safety Records Bureau upon request.

4. I hereby release from liability and promise to hold harmless under any and all causes of legal action, the State of Nevada, its officer(s), agent(s) and/or employee(s) who conducted my criminal history records search and provided information to the submitting agency for any statement(s), omission(s), or infringement(s) upon my current legal rights. I further release and promise to hold harmless and covenant not to sue any persons, firms, institutions or agencies providing such information to the State of Nevada on the basis of their disclosures. I have signed this release voluntarily and of my own free will.

A reproduction of this authorization for release of information by photocopy, facsimile or similar process, shall for all purposes be as valid as the original.

Applicant's Name: TAYLOR DeSHAWN LAKISHA
(LAST FIRST MIDDLE)

Address: [redacted]

Applicant's Signature: [signature]

Date: 1/2/13

Submitting Agency: Nevada State Board of Medical Examiners

Address: 1105 Terminal Way, Ste # 301, Reno, NV 89502

Agency representative: Daniels, Lynnette, L.
(PLEASE PRINT LAST, FIRST, MIDDLE

Agency representative's Signature: [signature]

Date: 2/13/2012